CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 28, 2000

H.R. 2966
Keep Our Promise to America's Military Retirees Act

As introduced on September 28, 1999

SUMMARY

H.R. 2966 would increase health insurance benefits for certain retirees from the uniformed services and their survivors. Retirees who entered military service before June 7, 1956, and their surviving spouses would be able to use one of the military health insurance programs—Tricare Standard or Extra—and would also be able to enroll in the Federal Employees Health Benefits (FEHB) program. Those enrolling in FEHB would pay no out-of-pocket premiums. The Department of Defense (DoD) would pay the normal government contribution (roughly 70 percent) as well as the remaining share of the premium normally paid by the annuitant.

Retirees who entered military service after June 7, 1956, and their survivors would be eligible for increased insurance coverage after they turned age 65. They could either enroll in FEHB or continue to use Tricare Standard or Extra, but could not choose both options. For those choosing FEHB, DoD would pay only the normal government contribution and the retiree or survivor would be responsible for the remainder. DoD would also bear costs for those retirees and survivors who choose to continue their use of Tricare Standard or Extra. (Under current law, eligibility to use those programs ends at age 65.)

The bill would result in additional costs for spending on FEHB premiums, increased use of Medicare, and increased use of Tricare. Because the bill would affect direct spending, pay-as-you-go procedures would apply. Allowing for a transition period lasting three years, CBO estimates that the bill would raise direct spending by about $30 billion over the 2001-2005 period and by roughly $74 billion through 2010. The bill would necessitate additional discretionary spending of $1.5 billion over the 2001-2005 period, assuming appropriation of the necessary amounts.

H.R. 2966 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2966 is shown in Table 1. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 050 (national defense).

TABLE 1. ESTIMATED COSTS OF H.R. 2966

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	2,500	4,700	6,800	7,700	8,000
Estimated Outlays	0	2,500	4,700	6,800	7,700	8,000
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	110	200	340	440	530
Estimated Outlays	0	100	190	320	420	510

BASIS OF ESTIMATE

Under current law, military retirees under the age of 65 are eligible either to enroll in Tricare Prime or to use Tricare's insurance programs (Standard or Extra). Those who use Tricare Standard or Extra may also seek care at a military treatment facility (MTF) on a space-available basis. Once retirees turn age 65, they are no longer eligible to use Tricare, though they may continue to seek care at an MTF when space is available. The same eligibility rules apply to survivors, who are primarily widows and widowers.

H.R. 2966 would allow greater access to health insurance by allowing retirees and survivors over the age of 64 the added choice of insurance under Tricare and FEHB in addition to their Medicare benefit and any private insurance they already have. Retirees who entered military service before June 7, 1956, and their surviving spouses would be eligible to enroll in FEHB and to use Tricare Standard or Extra. Retirees and survivors who do not meet that test would be able to choose between enrolling in FEHB or using Tricare Standard or Extra once they turned age 65.

The bill would result in additional costs for spending on FEHB premiums, increased use of Medicare, and increased use of Tricare. The first step in calculating these costs is estimating the number of eligible beneficiaries.

Eligible Population

H.R. 2966 differentiates between two groups of beneficiaries. The first group consists of retirees who entered military service before June 7, 1956, and their surviving spouses. This group would be entitled to FEHB insurance without making any out-of-pocket premium payments and could also use Tricare Standard or Extra. Using data from the Department of Defense, CBO estimates that about 1.1 million households would meet the criteria for having their premiums paid in full. Reductions due to mortality will leave this population at a little more than 750,000 in 2010. According to the *1998 Health Care Survey of DoD Beneficiaries*, 10 percent of this population is already enrolled in FEHB. These individuals would also receive their FEHB insurance for free, but only a portion of their premiums would be new costs to the government.

The second group consists of retirees who entered military service after June 7, 1956, and survivors of an individual who entered service after that date. Those people would become eligible to enroll in FEHB after they turn age 65, or they could choose to use Tricare Standard or Extra, but they could not use both. Any member of this group choosing to enroll in FEHB would have to make the same out-of-pocket premium payments that current FEHB enrollees make. CBO expects that the number of beneficiaries not already eligible due to civil service employment after their military careers would reach about 380,000 by 2010.

Direct Spending

H.R. 2966 would increase costs for FEHB and Medicare. These costs would be direct spending and are shown in Table 2.

Costs of Premium Payments Under FEHB. DoD's contribution toward FEHB premiums for beneficiaries under H.R. 2966 would cost almost $27 billion over the 2001-2005 period and about $66 billion over the 10-year period ending in 2010. Premiums for retirees who would receive free insurance (those who entered service prior to June 7, 1956) would constitute the bulk of these costs. Even in 2010, after significant declines in this population from mortality, the cost of providing free premiums would still make up almost 90 percent of the added FEHB costs—$7.3 billion out of $8.4 billion. The expected increase in FEHB premiums is greater than the mortality rate, so total costs would continue to increase over the 2001-2010 period.

TABLE 2. ESTIMATED DIRECT SPENDING UNDER H.R. 2966

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
DIRECT SPENDING						
Costs of Premium Payments for FEHB						
Spending Under Current Law						
Estimated Budget Authority	5,012	5,456	5,906	6,352	6,826	7,338
Estimated Outlays	5,012	5,456	5,906	6,352	6,826	7,338
Proposed Changes						
Estimated Budget Authority	0	2,300	4,300	6,200	6,900	7,100
Estimated Outlays	0	2,300	4,300	6,200	6,900	7,100
Spending Under H.R. 2966						
Estimated Budget Authority	5,012	7,756	10,206	12,552	13,726	14,438
Estimated Outlays	5,012	7,756	10,206	12,552	13,726	14,438
Cost Increases in Medicare						
Spending Under Current Law						
Estimated Budget Authority	216,900	234,800	242,500	263,000	282,200	308,500
Estimated Outlays	216,900	234,800	242,500	263,000	282,200	308,500
Proposed Changes						
Estimated Budget Authority	0	200	400	600	800	900
Estimated Outlays	0	200	400	600	800	900
Spending Under H.R. 2966						
Estimated Budget Authority	216,900	235,000	242,900	263,600	283,000	309,400
Estimated Outlays	216,900	235,000	242,900	263,600	283,000	309,400
Total Proposed Changes						
Estimated Budget Authority	0	2,500	4,700	6,800	7,700	8,000
Estimated Outlays	0	2,500	4,700	6,800	7,700	8,000

Participation Rates. CBO estimates that by 2003 about 950,000 (90 percent) of retirees and survivors who would be eligible for free FEHB coverage would enroll in FEHB. By 2010, the estimated number of participants would be less than 700,000. Because they would pay no premiums, the overwhelming majority of these people would probably choose to enroll in the most generous and, consequently, expensive plans like the Blue Cross/Blue Shield (BCBS) High option. Under the provisions of H.R. 2966, such retirees would also be

eligible to use Tricare Standard or Extra. Tricare use would likely be limited to covering out-of-pocket medical care costs that beneficiaries would incur using FEHB. Because BCBS High is more generous and has lower catastrophic limits than Tricare, CBO expects that retirees and survivors would choose FEHB as their primary insurance.

In contrast, a much lower percentage of the other retirees and survivors would choose to enroll in FEHB. Using data from the *1998 Health Care Survey of DoD Beneficiaries* and the *Current Population Survey* (March 1997), CBO estimates that roughly 50 percent of military retirees who are working in a second career for the federal government currently choose to pay an out-of-pocket premium to enroll in FEHB. They do this despite being eligible for Tricare Standard or Extra, for which there is no such premium. CBO uses the same estimated participation rate (50 percent) for retirees who would pay part of the premium under H.R. 2966 because they would face the same choice as current retirees employed by the federal government as civilians.

Currently, DoD and the Office of Personnel Management (OPM) are conducting a pilot program that allows military retirees age 65 and over to enroll in FEHB for a two-year period. Although enrollment rates have been extremely low, CBO does not believe these rates are representative of what would happen if H.R. 2966 became law. CBO believes that the temporary nature of the program is the primary reason participation rates are low. According to data from the *1997 Health Care Survey of DoD Beneficiaries*, about 55 percent of retirees and survivors currently purchase some form of medigap insurance. Those who enroll in the FEHB demonstration program may not be aware that they can reacquire their medigap coverage at the end of two years, which would explain why so many are reluctant to enroll in the plan.

Premium Costs to the Federal Government. CBO estimates the added per capita FEHB costs by using the premium rates published by OPM for 2000. BCBS High option premiums are $3,773 for an individual policy and $8,068 for a family policy. The BCBS Standard option premiums are $2,831 and $6,312, while Kaiser Permanente's Mid-Atlantic premiums are $2,444 and $6,042. The government pays a fixed amount equal to 72 percent of the average premium (weighted by participation in the various plans), but for expensive plans the actual share is considerably less than 72 percent.

The government's costs would increase significantly under H.R. 2966 because a large group of beneficiaries would receive health insurance and pay no premiums. In 2001, CBO estimates that the average cost to the federal government for retirees and survivors not paying premiums would be $3,971 for individuals and $8,550 for families. In contrast, if the enrollees were to pay their share of the premiums the costs to the federal government would be $2,177 for individuals and $4,959 for families. According to data from DoD, 66 percent

of retirees age 65 and over have at least one dependent and would likely choose the self-and-family policy.

CBO also estimates that about 80 percent of enrollees who would not receive free insurance would choose a fee-for-service plan like BCBS, and about 20 percent would opt for a managed care plan. These percentages correspond to actual enrollment data for Civil Service retirees who are currently enrolled in FEHB.

CBO believes that H.R. 2966 would not significantly change the level of risk in the FEHB insurance pool. Accordingly, estimated premiums for all current FEHB enrollees would remain unaffected. New beneficiaries under H.R. 2966 would be considerably older than the corresponding pool of federal civilian enrollees. Based on self-reported evaluations, the health status of the potential beneficiaries is somewhat poorer than for current FEHB enrollees. However, almost all of those military beneficiaries are over age 64 and eligible for Medicare and about 90 percent enroll in Medicare Part B. When retirees are covered jointly by Medicare and FEHB, Medicare pays first and FEHB acts as a wrap-around policy, which significantly lowers the costs to FEHB. For example, under current law annuitants who are covered by Medicare and active employees cost the federal government about the same per capita amount for FEHB. In absolute terms, annuitants cost a lot more, but since Medicare is first payer the actuarial costs to FEHB are about equal for both groups. H.R. 2966 would add a sizable population that is somewhat more likely to require health care services than current FEHB enrollees, but since Medicare is first payer the effect is probably negligible.

Cost Increases in Medicare. Allowing military retirees the opportunity to enroll in FEHB plans or to use Tricare insurance would also increase costs to the Medicare program. CBO estimates that H.R. 2966 would increase Medicare costs by $2.9 billion over the 2001-2005 period and by almost $8 billion over the first 10 years. This increase would stem from increased use of health care by those retirees for whom FEHB/Tricare provides better insurance than they currently receive. In addition, some retirees would seek care from private providers instead of an MTF once they have a generous health insurance plan.

Retirees enrolled in Medicare who do not have a medigap plan or employer-sponsored insurance are likely to increase their use of health care once they receive supplemental insurance. CBO estimates that this group makes up roughly 13 percent of the beneficiaries who are over the age of 64 and who do not currently use MTFs for their medical care. The estimate is based on the *1997 Health Care Survey of DoD Beneficiaries*, which provides self-reported data on private insurance coverage. Although Medicare is currently the primary payer for these people, it would have to pay more because more generous insurance encourages more use of health care services. Using data from published research, CBO

estimates that Medicare costs for these individuals would rise by about 25 percent as they gain better coverage.

Many retirees seek health care at MTFs, but there is a significant amount of variation in the degree to which those people use MTFs. With the provision of better insurance fewer people would use MTFs and would turn instead to the private sector. This shift in the provision of care would increase costs to Medicare, which is the first payer under most health insurance policies. CBO estimates that about 6 percent of beneficiaries over age 64 would effectively begin using private health care providers rather than the military health system.

Spending Subject to Appropriation

H.R. 2966 would also raise discretionary spending by DoD, assuming appropriation of the estimated amounts. The estimated changes in spending subject to appropriation are shown in Table 3. CBO estimates that changes in MTF caseloads would initially yield discretionary savings, but such savings would be more than offset by an increase in other Tricare costs. On balance, we estimate an increase in discretionary costs of $100 million in 2001 and about $1.5 billion over the 2001-2005 period.

Changes in MTF Caseload. Access to FEHB and Tricare would represent a significant improvement in insurance coverage for many beneficiaries age 65 and over. Retirees who enroll in FEHB would use MTFs less frequently, especially those who would receive FEHB for free. CBO estimates that roughly 30,000 users would leave the military health care system in 2001 and about 75,000 users would leave by 2010. According to DoD estimates, the costs of direct patient care for these beneficiaries averages $2,340 per person. By 2005 these savings would total about $230 million in outlays.

CBO estimates that about 30 percent of those not eligible for free FEHB insurance would choose to enroll in Tricare, increasing the number of users in the military health care system. These additions are relatively small in the early years but would become more substantial by 2010. CBO estimates that the number of Tricare users would increase to a little more than 180,000 by 2010. CBO estimates that DoD's cost under Tricare Standard or Extra of providing care to these retirees and survivors over the age of 64 would be about 80 percent of the cost of the BCBS High individual premium, or roughly $3,000 per person in 2000. By 2005, these costs would reach about $270 million in outlays. The net result is savings for the first four years and gradually rising costs over the last six years of the 2001-2010 period.

TABLE 3. ESTIMATED SPENDING SUBJECT TO APPROPRIATION UNDER H.R. 2966

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,500	16,500	16,500	16,500	16,500
Estimated Outlays	16,500	16,500	16,500	16,500	16,500	16,500
Proposed Changes						
Changes in MTF Caseload						
Estimated Authorization Level	0	-60	-110	-100	-30	50
Estimated Outlays	0	-50	-100	-100	-40	40
Tricare as Third Payer						
Estimated Authorization Level	0	170	310	440	470	480
Estimated Outlays	0	150	290	420	460	470
Subtotal-Proposed Changes						
Estimated Authorization Level	0	110	200	340	440	530
Estimated Outlays	0	100	190	320	420	510
Spending Under H.R. 2966 for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,610	16,700	16,840	16,940	17,030
Estimated Outlays	16,500	16,600	16,690	16,820	16,920	17,010

a. The 2000 level is the estimated amount appropriated for that year. The current law amounts for the 2001-2005 period assume that appropriations remain at the 2000 level, without adjustment for inflation. If they are adjusted for inflation the base amounts would increase by about $400 million a year, but the estimated changes would remain as shown under "Proposed Changes."

Tricare as Third Payer. Under H.R. 2966, those eligible for free FEHB benefits can also use Tricare Standard or Extra to offset some of their out-of-pocket costs under FEHB. CBO estimates that in 2000 the average out-of-pocket costs for Medicare-eligible FEHB users would be roughly $600 for individuals and about $1,000 for a family of two. CBO estimates that by 2005 the costs to DoD from this benefit would be about $470 million, based on an estimated 1.1 million households that would be eligible for the benefit in 2001.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	2,500	4,700	6,800	7,700	8,000	8,300	8,600	8,900	9,200	9,500
Changes in receipts	Not applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 2966 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

ESTIMATE PREPARED BY:

Federal Costs: Sam Papenfuss
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: Rachel Schmidt

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis